Quality is Our Bottom Line

September 12, 2013

Margo Lachowicz
Access Health CT
Connecticut Health Insurance Exchange
280 Trumbull Street
15th Floor
Hartford, CT 06103

RE: Public Comment: Policies and Procedures: All-Payer Claims Database

Dear Margo:

On behalf of the Connecticut Association of Health Plans and its member companies including Aetna, Anthem, ConnectiCare, Cigna, United and Harvard Pilgrim, please accept the attached document in accordance with the public comment period on the "draft" All-Payer Claims Database Policies and Procedures as published in the Connecticut Law Journal.

Draft CT APCD Policies and Procedure Comments

As a general principal, the Connecticut Association of Health Plans respectfully requests that CT adopt the X12 standard format as is and work with interested parties to modify the current standards where needed. The CT APCD requires some data elements that are not in the X12 standard. However, the X12 standard contains a robust set of data elements that would provide useful information to CT. It is also suggested that for health plans who do not have the X12 transaction creation capability, the APCD shall accept the X12 format with a timeline and understanding that the transition to the X12 transaction will occur.

With respect to the Association's specific concerns, please note the following comments:

Comment 1: Data Utilization and Disclosure Section Concerns and Request for Modification

One critical area that the Exchange should consider concerns the instances in which the release of data to certain entities identifying specific rates of payment to providers by health plans could lead to anti-competitive activities. While the intent of the Exchange's Data Utilization and Disclosure Section of the APCD Policies and Procedures is to promote open information to CT consumers this activity could lead to

adverse effects on overall market competition that is not in the interest of consumers, and will threaten the state's efforts to achieve the health care cost benchmarks it most likely wants to accomplish. The Exchange's APCD Data Utilization and Disclosure Section should include a provision that provides it with discretion to protect against the potential for anti-competitive activities by certain entities that may request APCD data that identifies specific rates of payment by health plan name to providers.

At a federal level, antitrust regulators have recognized the tension between facilitating better information for consumers while limiting the potential for anticompetitive behavior. Under the Sherman Anti-Trust Act, the primary purpose of limited anticompetitive behavior, including collusion to depress prices or artificially inflate prices, is to benefit consumers. As an example, in response to proposed California legislation regarding price transparency, the Department of Justice (DOJ) and Federal Trade Commission (FTC) (the entities that enforce antitrust actions or violations) jointly noted, "Whenever competitors know the actual prices charged by other firms, tacit collusion – and thus higher prices – may be more likely."

The Exchange's proposed APCD Data Utilization and Disclosure language for permitting access to data to consumer and public and private entities should follow and meet the methodological requirements outlined by the DOJ and FTC (see Attached DOJ/FTC Statements of Antitrust Enforcement Policy in Health Care – Statement 6). The DOJ/FTC policy on health care antitrust enforcement states, that without appropriate safeguards or protections, the exchange or release of proprietary or confidential information could facilitate collusion, reduce completion and increase prices and the availability of health care services, all to the detriment of consumers – the patients. Disclosure of a health plan's proprietary or confidential information in its raw form runs counter to the DOJ/FTC policy statement and would not be in the public's interest. Instead it would have the opposite effect, creating potential and serious anti-trust violations and undermine the cost containment goals of the Exchange's APCD Data Utilization and Disclosure Section. Acknowledgement of the protection of the proprietary interests of both providers and payers needs to be stated clarifying that only the release of de-identified data and not expanded limited data sets will be released confirming that no data release will identify payer or provider fee schedules.

Given these serious potential issues, again, we ask that the Exchange review data requests for APCD disclosure to determine whether the release or use of data will not result in collusion or anti-competitive conduct and is not expected to increase the cost of health care for consumers in Connecticut by releasing a health plan's identifiable proprietary or confidential information. Furthermore, we would respectfully suggest that specific data request policies along with data usage and release policies be developed and published as a component of the regulation. With that, we offer the following changes in bold to the APCD Data Utilization and Disclosure Section:

> The Exchange will utilize data in the APCD to provide health care consumers in the state with information concerning the cost and quality of health care services that will allow such consumers to make economically sound and informed health care decisions.
>
> The Exchange will make standard, aggregated reports containing information regarding utilization, cost and quality of services available to health care consumers. **Any data or reports made available to consumers will not facilitate collusion or anti-competitive conduct and is not expected to increase the cost of health care. Only the release of de-identified data shall be provided.**

The Exchange may make data available in such form or forms as it deems appropriate to health care consumers and public and private entities engaged in reviewing health care utilization, cost, or quality of health care services, including community and public health assessment activities, in accordance with future Policies and Procedures to be promulgated by the Exchange. **Any release or use of data made available to consumers and public and private entities will not facilitate collusion or anti-competitive conduct and is not expected to increase the cost of health care. The Exchange will also consider this provision in any future Policies and Procedures adopted for the release or use of data.**

Comment 2: Waivers of Data Submission Requirements

The Association is concerned that the proposed schedules do not provide sufficient time for carriers to do the programming and testing/possible reprogramming and testing that carriers need, especially for a start-up APCD. If the time frames remain as they are, carriers will request extensions if they find they simply don't have enough time to do what is required. It typically takes a minimum of six months to program, test and submit the first data sets. Once the APCD is up and running, carriers need a minimum of 120 days to make changes that are minor in nature, and at least 180 days for more significant changes.

Currently, for the initial test files, historical data is due no later than 60 days after the due date for the test file specified. We ask that it be **"after final approval received from the state on the test files"** – if there are several iterations of submissions and state responses, the time period will extend beyond the 60 days; however a carrier can't program, test and submit the historical data until the test data is approved; nor would CT want carriers to submit historical data before test file approval.

Furthermore, given that some of the carriers claims processing systems may not be able to accommodate some of the fields/thresholds included in a Submission Guide, we would respectfully request that the Waivers of Data Submission Requirements Section be modified with the bold language: As a condition for granting a waiver, the Administrator may require a Reporting Entity to submit a plan for improving conformance to data submission requirements **when the Reporting Entity's system can be modified to include the fields/thresholds included in the Submission Guide when such modifications are not unduly burdensome and costly.**

Comment 3: Non-Compliance and Penalties

Please know that carriers will strive to meet the requirements ultimately adopted by the Exchange, but would respectfully suggest that if a carrier is making a good faith effort to comply they should not be subject to penalties during a time of such monumental transition within the entire health care delivery system. Specifically;

• With regard to the Exchange conducting audits of data submitted by Reporting Entities, such audits may not yield accurate results given system modifications and updates occurring between the time the data is produced and the time the data is audited. Such system modifications and updates may not enable the Exchange to produce the same data as the Reporting Entity initially submitted. If the Exchange insists on including a provision for auditing the accuracy of data, the Association of Health Plans suggests that the first sentence under the Non-Compliance and Penalties section be deleted and the following language be included as such:

[] **For the purpose of establishing protocols for auditing the accuracy of reported data, the Administrator may require Reporting Entities to validate findings and explain any questions regarding submitted data.**

• We ask that the following language be added back into the beginning of the current second paragraph: **"Except where a waiver has been granted by the Administrator,"**

• Given that Reporting Entities retain information for the purpose of conducting business and may not retain information requested by the Exchange, we ask that the following language be added in as the second sentence in the current second paragraph. **"A Reporting Entity will not be deemed a non-compliant Reporting Entity if it does not retain information that is unnecessary to conduct its business."**

• We ask that the following phrase in bold be added to the end of the first sentence in the third paragraph such that the first sentence will read: If a non-compliant Reporting Entity does not provide the required information or correct the deficiencies within thirty (30) days **or such other number of days that may be agreed to**, the Administrator may issue a notice of civil penalty to the non-compliant Reporting Entity.

Comment 4: Definitions

• Control Total File – Other APCD states include a header and trailer record within the file to capture similar information. We recommend that the Exchange incorporate header and trailer records and remove the Control Total File reference and requirements from the Policy and Procedure as well as the Data Submission Guide documents.

• Historic Data - Other APCD states have consistently requested three years of historic data. We ask that this section be modified to reflect historic data will commence in the month the Submission Guide is finalized with a three year look back period.

• Member and Subscriber – The Policy and Procedures document includes definitions for Member and Subscriber. The Data Submission Guide includes a definition for Connecticut resident. These definitions are not consistent. We ask that the terms Member, Connecticut resident and Subscriber be used in both documents with consistent definitions in each document.

Comment 5: Reporting Entities Data Submission Schedule

• Test Files – The request for 12 consecutive months of data for test files is inconsistent with what other APCD states have requested as part of their APCD testing. We recommend that a one month period of data be submitted in the test files. We recommend that the due date for submission of test files be changed to 180 days after the issuance of the Final Submission Guide.

• Historic Data – We recommend that the historic data be due 90 days after the due date of the test files.

Draft CT APCD Data Submission Guide Comments

Comment 1: Documentation Supporting Data Extract Files

The Association of Health Plans requests an explanation for and clarification of the following section so that we can better respond to the Exchange's request. We are concerned that this section may be unduly burdensome to carriers submitting data to the APCD. Currently, there is no other state to our knowledge that requires this type of information. If the purpose is to determine whether the data submitted is complete and responsive to the requirements, we are concerned that the requested material will not be informative because the CT APCD team may not be familiar with our systems, products and data stores over time, and as such would not be able to draw conclusions or make decisions based upon the information. In addition, certain data specifications could give rise to the concerns expressed in Comment 1 above around the accessibility of competitive information. ***Our strong recommendation is that this section be removed.***

> Section II.7 Each Reporting Entity must submit documentation supporting their standard data extract files, including a data dictionary mapping internal system data elements to the data elements defined in this DSG. The documentation should include a detailed description of how the data extracts are created and how the requirements of this DSG and the rule are accomplished, including specifications on what data is being excluded and the parameters that define that excluded data.

Comment 2: Data Submission Requirements; General Information

Item 6 states the following: Reporting Entities will submit files on a monthly basis to the APCD Data Manager, which will operate and maintain a secure file transfer portal for this project.

a. All claims data is to be submitted within one month after the close of the previous reporting month. EXAMPLE: Claims adjudicated by the payer in January are to be reported by the end of February in the January File.

b. All eligibility data is to be submitted monthly for any and all active eligibilities for the month as of the 15th of that month. The reporting of an inactive member is allowed and can be accounted for in the data set, but there is no rolling-period methodology required.

c. All provider data is to be submitted monthly for any and all active provider contracts the payer has with a health care provider or health care vendors as of the 15th of the month. The reporting of inactive providers is allowed and can be accounted for in the data set, but there is no rolling-period methodology required.

We ask for a clarification of the meaning of "the 15th of the month." Please specify which month. Please also explain how this affects the due date for each monthly submission.

More importantly, we respectfully submit that monthly submission of data is very cumbersome and entails significant administrative expense on both the sending and receiving parties. As such, the Association would strongly suggest modifying the requirement to be quarterly instead which significantly reduces the administrative expense while not compromising the intent of the regulation.

Should the monthly requirement stand, a process should be developed for the submission of reversals, resubmissions or other types of time-dependent edits that can occur within the claims processing system so as not to compromise the quality of the database from a reporting and research perspective.

Comment 3: Data Submission Requirements; General Information; Scope of Provider File

Section II. 6. c. indicates: All provider data is to be submitted monthly for any and all active provider contracts the payer has with a health care provider or health care vendors as of the 15th of the month.

Section III. A. 4. indicates: Reporting Entities must provide a data set that contains information on every provider with paid claims in the Medical Claims file during the targeted reporting period. Every Provider on a record in the Medical Claims file should have a corresponding record in the Provider file.

Page 6 of 9 The scope of the provider file outlined in Section III. A. 4. is consistent with the provider file requirements in other APCD states. ***We ask that references to provider file scope be modified to reflect the language in Section III. A. 4.***

Comment 4: Section II: Required Data Files: Dental Claims Data

The reference to rules within ***Section II. A. 6. should be changed to Policies and Procedures***.

Comment 5: Definitions and Acronyms

Health Care Data – This definition includes a reference to Pharmacy Claims twice. ***Please remove one of the references.***

Comment 6: Data Element Thresholds

We ask that the Exchange refrain from assigning threshold levels until they receive the initial set of test files from the Reporting Entities so that the levels can be set based on what the Reporting Entities are able to report.

Comment 7: Medical Claims Data Field Clarification Request

• Type – External Code Source – HIPAA, USPS, NUBC, NPPES, WPC, CMS, ICD, AMA, ANSI, FDA, HIPPA; ***Please provide a specific reference for or URL for each of the External Code Sources.***

• MC038 – Claim Status – Data type is referring to a lookup table. ***Please indicate where within the Data Submission Guide the lookup table is located or which lookup table a Reporting Entity should use***.

• MC042-MC053 (DX1 – DX12) - Required percentages are 70%, 24%, 13%, 7%, 4%, 3%, 3%, 2%, 1%, 1%, 1%, 1% respectively. The Element Submission Guideline indicates "If not applicable do not report any value here." If a field is "not applicable," please explain why there are threshold percentages. ***We recommend that the threshold percentages be deleted***.

• MC097 – Medicare Paid Amount – ***Please confirm then specify in the Data Submission Guide whether this is for Original Medicare only and not applicable to Medicare Advantage plans***.

• MC142-MC153 (DX13 – DX24) – Required percentage is 1%. Element Submission Guideline indicates "If not applicable do not report any value here." If a field is "not applicable," please explain why there is a threshold percentage. ***We recommend that the threshold percentages be deleted***.

• MC061 – Quantity - Claim line units of service. Report the count of services / units performed. ***Please include an explanation for what is required in this field.***

• MC080 – Payment Reason - Report the value that describes how the claim line was paid, either using a standard code set or a proprietary list pre-sent by submitter. ***Please explain what should be reported in this field.*** We are concerned about releasing proprietary information that may be re-released to the public.

• MC115 – Medicare Indicator – ***Please confirm then specify in the Data Submission Guide whether this is for Original Medicare only and not applicable to Medicare Advantage plans.***

• MC124 – Denial Reason - Report the code that defines the reason for denial of the claim line. Carrier must submit denial reason codes in separate table to the APCD. ***Please provide additional information to explain what should be reported in this field.***

• MC191 – Value code – 1; Required percentage is 100% The Element Submission Guideline indicates: "Report the appropriate value that defines a value category for the claim or the patient. If not applicable do not report any value here." If a field is "not applicable," please explain why there is a threshold percentage. ***We recommend that the threshold percentage be deleted.***

Comment 8: Pharmacy Claims Data Field Clarification Request

• Type – External Code Source – HIPAA, USPS, NPPES, ANSI, FDA, NCPDP, ICD; ***Please provide a specific reference for or URL for each of the External Code Sources.***

Comment 9: Dental Claims Data Field Clarification Request

• Type – External Code Source – HIPAA, USPS, NPPES, WPC, CMS, ADA, AMA, ICD, NUBC; ***Please provide a specific reference for or URL for each of the External Code Sources.***

• Reporting Entities that are medical payers may have an occasional dental claim related to treatment in a medical facility. Are those Reporting Entities required to submit monthly dental files for each commercial entity? If so, ***please include a reference to this requirement within the Data Submission Guide.***

• Although the Data Submission Guide specifies that dental reporting will be deferred until after medical reporting is implemented and that specifications would be developed after soliciting reporter input, yet there is a dental file layout specification in the document. ***Please clarify the Exchange's plans for soliciting reporter input.***

• DC049 – Tooth Surface required when DC047 (tooth number) is populated. There are many dental procedures for which a tooth number but not a surface will be specified. One example is an extraction. The entire tooth is extracted without treatment to a specific surface. ***Please modify the condition to read Optional.***

Comment 10: Eligibility Data Field Clarification Request

• Type – External Code Source – 2 – Text, CDC, Census, NPPES, NAICS; ***Please provide a specific reference for or URL for each of the External Code Sources.***

• ME077 - Member's North American Industry Code (NAICS). ***We request that this field be changed to SIC code which is readily available.***

Comment 11: Provider Data Field Clarification Request

• Type – External Code Source – USPS, WPC, 4-Integer, NPPES; ***Please provide a specific reference for or URL for each of the External Code Sources.***

• ***Please explain the Element Submission Guideline for field PV02***. The Element Submission Guideline reads: NOTE: ID Link to PV056, ME036, ME046 MC024, MC076, MC112, MC125, MC134, PC043, PC050, PC059, DC018 • Please indicate whether or not the following elements will be included in the Provider File Data specifications: o PV013 – Entity Code/Facility Code o PV029 – Provider Type Code o PV031 – Provider Organization ID o PV032 – Registered Provider Organization ID

Comment 12: Control Total Data Field Clarification Request

If the Control Total File will remain in the Policy and Procedure and Data Submission Guide, we have the following questions regarding the fields noted below.

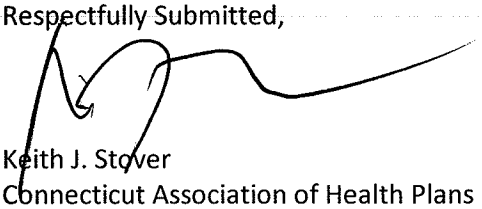
• CF005 though CF 012, ***the Condition should state "Required when CF004 = 1"***. Currently the condition refers to CF002 which is the Reporting Period Start Date.

• CF014 – Monthly Claims Paid and CF015 – Monthly Net Dollars Paid – ***Please specify whether or not separate totals for each product name listed in CF011 are expected with each month's submission***.

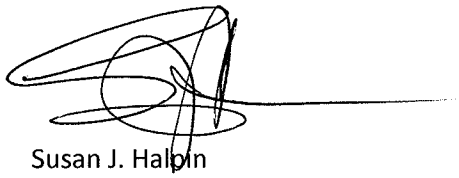
Again, carriers will strive to provide all of the data elements required and to meet the expected thresholds, however, carriers may not have all of the data available or be able to meet all of the thresholds listed. It's important to note that there are some health care reform related fields which are not yet available.

Many thanks for your consideration. As always, the Association and its members stand poised to work with Exchange toward the implementation of a successful APCD in the State of Connecticut. Please let us know if you have any questions or concerns regarding these comments.

Respectfully Submitted,



Keith J. Stover
Connecticut Association of Health Plans



Susan J. Halpin
Connecticut Association of Health

*****STATEMENT OF DEPARTMENT OF JUSTICE AND FEDERAL TRADE COMMISSION ENFORCEMENT POLICY ON PROVIDER PARTICIPATION IN EXCHANGES OF PRICE AND COST INFORMATION**

Introduction Participation by competing providers in surveys of prices for health care services, or surveys of salaries, wages or benefits of personnel, does not necessarily raise antitrust concerns. In fact, such surveys can have significant benefits for health care consumers. Providers can use information derived from price and compensation surveys to price their services more competitively and to offer compensation that attracts highly qualified personnel. Purchasers can use price survey information to make more informed decisions when buying health care services. **Without appropriate safeguards, however, information exchanges among competing providers may facilitate collusion or otherwise reduce competition on prices or compensation, resulting in increased prices, or reduced quality and availability of health care services.** A collusive restriction on the compensation paid to health care employees, for example, could adversely affect the availability of health care personnel.

This statement sets forth an antitrust safety zone that describes exchanges of price and cost information among providers that will not be challenged by the Agencies under the antitrust laws, absent extraordinary circumstances. It also briefly describes the Agencies' antitrust analysis of information exchanges that fall outside the antitrust safety zone.

A. Antitrust Safety Zone: Exchanges Of Price And Cost Information Among Providers That Will Not Be Challenged, Absent Extraordinary Circumstances, By The Agencies

The Agencies will not challenge, absent extraordinary circumstances, provider participation in written surveys of (a) prices for health care services, or (b) wages, salaries, or benefits of health care personnel, if the following conditions are satisfied:

1. the survey is managed by a third-party (e.g., a purchaser, government agency, health care consultant, academic institution, or trade association); 2. the information provided by survey participants is based on data more than 3 months old; and 3. there are at least five providers reporting data upon which each disseminated statistic is based, no individual provider's data represents more than 25 percent on a weighted basis of that statistic, and any information disseminated is sufficiently aggregated such that it would not allow recipients to identify the prices charged or compensation paid by any particular provider.

The conditions that must be met for an information exchange among providers to fall within the antitrust safety zone are intended to ensure that an exchange of price or cost data is not used by competing providers for discussion or coordination of provider prices or costs. They represent a careful balancing of a provider's individual interest in obtaining information useful in adjusting the prices it charges or the wages it pays in response to changing market conditions against the risk that the exchange of such information may permit competing providers to communicate with each other regarding a mutually acceptable level of prices for health care services or compensation for employees.
B. The Agencies' Analysis of Provider Exchanges Of Information That Fall Outside The Antitrust Safety Zone

Exchanges of price and cost information that fall outside the antitrust safety zone generally will be evaluated to determine whether the information exchange may have an anticompetitive effect that outweighs any procompetitive justification for the exchange. Depending on the circumstances, public,

non-provider initiated surveys may not raise competitive concerns. Such surveys could allow purchasers to have useful information that they can use for procompetitive purposes.

Exchanges of future prices for provider services or future compensation of employees are very likely to be considered anticompetitive. If an exchange among competing providers of price or cost information results in an agreement among competitors as to the prices for health care services or the wages to be paid to health care employees, that agreement will be considered unlawful per se.